DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES
CENTERS FOR	MEDICARE	& MEDICAID	SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAIN	OF CORRECTION	155755	A. BUILD		03	07/27/2011	
		100700	B. WIN		A DEPENDE OF THE OWN CORP.	0112112	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I YEARS HOMESTE	EAD			OEGLEIN ROAD WAYNE, IN46815		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety Co	ode Recertification	K(	0000	Ms. Kim Rhoades Indiana St		
	and State Licen	sure Survey was			Department of Health 2 North Meridian Street Indianapolis,		
	conducted by tl	ne Indiana State			46204Dear Ms. Rhoades: Pl		
	Department of	Health in			find our Plan of Correction fo		
	accordance witl	n 42 CFR 483.70(a).			our Annual Life Safety Code Survey conducted in our		
	Survey Date: 0	7/27/11			community July 27, 2011. O date of compliance is August 2011. Please contact me if you	: 25, ou	
	Facility Number	r: 000282			need any further information	or	
	Provider Numbe				details. Sincerely, Dianna Holmes, MSW, HFA Adminis	trator	
	AIM Number: 1				The creation and submission		
	Surveyor: Amy Code Specialist  At this Life Safe Golden Years H found not in co Requirements f Medicare/Medicare/Medicare from Fire and the National Fire Association (NF Code (LSC), Characteristics)	Kelley, Life Safety  ety Code survey, omestead was mpliance with or Participation in caid, 42 CFR (a), Life Safety he 2000 edition of the Protection (PA) 101, Life Safety			this Plan of Correction does constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Creck Allegation and requests a Posurvey Review on or after Au 25, 2011.	not nis et on of d dible est	
	·	facility with a nt was determined (111) construction					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

YFM821

Facility ID:

000282

TITLE

If continuation sheet

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155755		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  03	(X3) DATE SURVEY COMPLETED 07/27/2011	
	PROVIDER OR SUPPLIER		3136 (	ADDRESS, CITY, STATE, ZIP CODE GOEGLEIN ROAD WAYNE, IN46815	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	facility has a firm with smoke detections, space corridors, space corridors and refacility has a case census of 100 as survey.  Quality Review by I Code Specialist-Medical Compliance with aforementioned	es open to the esident rooms. The pacity of 106 and a at the time of this Robert Booher, Life Safety dical Surveyor on 08/03/11.			
K0025 SS=D	least a one-hour fi accordance with 8 terminate at an atr protected by fire-ra glass panels in ap of two separate co on each floor. Dan duct penetrations ducted heating, ve	ms. 18.3.7.3, 18.3.7.5, vation and	K0025	This provider has smoke barriers that are constructo provide at least a one-hour	

000282

STATEMEN	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	03	COMPLETED		
		155755	B. WIN			07/27/2011		
		II.	P		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	OEGLEIN ROAD			
GOLDEN	YEARS HOMEST	EAD			VAYNE, IN46815			
			_	L		(3/5)		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE		
1110		·	<u> </u>	1710	resistance rating in accorda			
	ensure 1 of 1 o				with 8.3. We have smoke			
		aintained to provide			barriers that may terminate	at		
	a one hour fire	resistance rating.			an atrium wall. Windows a	• • • • • • • • • • • • • • • • • • •		
	LSC 8.3.2 requ	ires smoke barriers			protected by fire-rated glaz	ing		
	shall be contin	uous from an			or by wired glass panels in			
	outside wall to	an outside wall.			approved frames. A minim			
	This deficient	oractice was not in a			of two separate compartme	I		
	1	rea but could affect			are provided on each floor.			
	any number of				What corrective action(s) w	'III		
	any number of	stair.			be accomplished for those residents found to have been	on l		
	l <u>.</u>				affected by the deficient	511		
	Findings includ	le:		practice? No resident was				
					affected by the alleged			
	Based on an ol	oservation with the			deficient practice.How will	you		
	Facility Engine	er on 07/27/11 at			identify other residents hav	ring		
	12:15 p.m., the	ere were twenty			the potential to be affected	by		
	•	enetrations in the			the same deficient practice			
	mezzanine are				what corrective action will I			
	mechanical roo				taken?Areas identified will be	e fire		
					caulked by our contractor, Hambrock Electric. They we	uro.		
	electronic equi				responsible for the installatio	• • • • • • • • • • • • • • • • • • •		
	I	ere located. Twenty			and fire caulking. Hambrock			
	of the penetrat	ions were left			Electric was contacted on			
	unsealed. The	gaps were one			7/6/2011 and can commit to			
	fourth inch or	less around the			having the required work			
		Additionally, one of			completed no later than	.:u		
		ines extending from			8/25/2011. What measures what be put into place or what	VIII		
		_			systemic changes you will			
	the side wall was not provided with fire stop material. This was				make to ensure that the			
					deficient practice does not			
	acknowledged	•			recur? The completion of the	e		
	Engineer at the	e time of			above stated work will ensur	• • • • • • • • • • • • • • • • • • •		
	observations.				alleged deficient will not recu	ır.		
					Environmental Services will			
	3.1-19(b)				visually inspect said areas fo	r		
	<b> </b>				proper completion of the	on(e)		
					work. How the corrective action	UII(8)		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE A. BUILDING B. WING	O3	(X3) DATE SURVEY COMPLETED 07/27/2011
	PROVIDER OR SUPPLIER		STREE 3136	T ADDRESS, CITY, STATE, ZIP CODE GOEGLEIN ROAD T WAYNE, IN46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K0027 SS=E	Door openings in sa 20-minute fire present 13/4-inch thick Non-rated protection 48 inches from the permitted. Horizon with 7.2.1.14. Swison that each door direction. Doors a bevels or astragals meeting edges. Prequired. 18.3.7.5 Based on obserinterview, the finensure 1 of 1 s smoke barrier of the movement least 20 minutes.	smoke barriers have at least otection rating or are at a solid bonded wood core. We plates that do not exceed to bottom of the door are not al sliding doors comply nging doors are arranged swings in an opposite re self-closing and rabbets, as are required at the ositive latching is not 18.3.7.6, 18.3.7.8 vation and accility failed to	K0027	will be monitored to ensure to deficient practice will not recise, what quality assurance program will be put into place Environmental Services will visually inspect said areas for proper completion of the work. Environmental Services monitor continued compliance through monthly visual inspections randomly X 6 monitor to make sure the electrical components are sealed and proper fire stop material is in place. Findings of the inspect will be reported to the Quality Assurance Committee who will determine the frequency of further audits.  This provider has door openings in smoke barriers that have at least a 20-minuting fire protection rating or are least 1 3/4 inch thick solid bonded wood core. Doors self-closing and rabbets, bevels or astragals are at the monitor of the protection of the protec	he ur, e: or s will be onths cions y vill onths of the at are he
	shall comply wi			meeting edges.What correct action(s) will be accomplish	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YFM821 Facility ID:

000282

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	03	COMPLETED
		155755	B. WING 07/27/2011			
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹			OEGLEIN ROAD	
GOLDEN YEARS HOMESTEAD				VAYNE, IN46815		
				<u> </u>	V/ (114E, 11440010	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		DATE
	8.3.4. LSC 8.3	.4.1 requires doors			for those residents found to	°
	in smoke barri	er shall close the			have been affected by the deficient practice? No resid	ont
	opening leavin	g only the minimum			was affected by the alleged	ent
	clearance nece	ssary for proper			deficient practice. How will y	ou l
		h is defined as 1/8			identify other residents have	
	_ ·	cient practice could			the potential to be affected	-
					the same deficient practice	
	affect any resid	dent in the Chapel.			what corrective action will	be
					taken?No resident was affect	ted
	Findings includ	de:			by the alleged deficient pract	
					The set of doors entering the	
	Based on obse	rvation with the			Chapel were fitted with a fire	
	Facility Engine	er on 07/27/11 at			rated door seal reducing the opening between the doors t	
	' '	smoke barrier door			meet the 1/8 inch	0
					requirement. What measures	s will
	_	e Chapel had a one			be put into place or what	
	fourth inch gar				systemic changes you will	
	doors. These s	smoke barrier doors			make to ensure that the	
	lack an astraga	ıl between the			deficient practice does not	
	doors. This wa	as acknowledged by			recur? The set of doors ente	· ·
	the Facility Eng	iineer.			the Chapel were fitted with a	
		,			rated door seal reducing the	
	3.1-19(b)				opening between the doors t meet the 1/8 inch requirement	
	3.1-19(b)				7/29/2011. This measure wi	
					ensure the deficient practice	
					not recur. Environmental	
					Services will monitor doors to	0
					ensure they meet the	_
					requirements. How the correct	
					action(s) will be monitored to	ı
					ensure the deficient practice not recur, i.e., what quality	VVIII
					assurance program will be p	ut
					into place: Environmental	
					Services will monitor doors to	o
					ensure they meet the	
					requirements. They will com	•
					random monthly inspections	x 6
	l					

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) M A. BUII B. WIN	LDING	03	(X3) DATE S COMPL 07/27/2	ETED
	PROVIDER OR SUPPLIER		•	3136 G	ADDRESS, CITY, STATE, ZIP CODE OEGLEIN ROAD NAYNE, IN46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0051 SS=C	according to NFPA warning of fire in a Activation of the coby manual fire alard detection, or exting Pull stations are lot Electronic or writte available. A reliablis provided. Fire a maintained in acconstitutional Fire Alarm maintenance are kis remote annuncia system to an appropriate appropriate of 1 states and the large basen was installed with mot adversely a operation. Secting and the large basen was installed with adversely a operation. Secting and the large basen was installed with the large basen was installed with adversely a operation. Secting and the large basen was installed with the large basen with the large basen was installed with the large basen was instal	ces or equipment is installed a 72, to provide effective any part of the building. Complete fire alarm system is an initiation, automatic guishing system operation. In cated in the path of egress. In records of tests are alle second source of power alarm systems are produce with NFPA 72, and Code, and records of teept readily available. There atton of the fire alarm oved central station.  Deservation and accility failed to moke detectors in ment storage room there air flow would affect their tion 9.6.1.4 form systems. TPA 72, National e. NFPA 72, es in spaces served systems detectors that of the stated where air flow tion of the stated in the practice of the stated where air flow tion of the stated in the practice of the stated where air flow tion of the stated in the practice of the provided in the provided in the provided in the provided in the path of the stated in the provided in the p	K	0051	months and report findings to Quality Assurance Committed who will determine if further inspections are required.  This provider's fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code a records of maintenance are kept readily available. What corrective action(s) will be accomplished for those residents found to have be affected by the deficient practice? No resident was affected by the alleged deficient other residents having the potential to be affected by same deficient practice and what corrective action will taken? No resident was affected by the alleged deficient practice and what corrective action will taken? No resident was affected by the alleged deficient practice and what corrective action will taken? No resident was affected by the alleged deficient practice.	nd e en ient ify the cted tice.	08/25/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YFM821

Facility ID:

000282

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	03	COMPLETED		
		155755	B. WIN			07/27/20	011	
			D. (11)		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	8		1	OEGLEIN ROAD			
GOLDEN	N YEARS HOMEST	EAD		1	VAYNE, IN46815			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					contacted and is adding 3 m	ore		
	Findings includ	le:			pull stations outside the neighborhood offices identification	od		
					These will be before the exit			
	Based on an ob	oservation with the			doors therefore will be acces			
		er on 07/27/11 at			at all times. Work completio	n is		
		smoke detector in			8/15/2011. <b>What measures v</b>	vill		
	· -				be put into place or what			
	1	ment storage room			systemic changes you will			
		enty five inches			make to ensure that the			
	·	oply duct. The air			deficient practice does not recur? Esco Communication			
	supply duct wa	is mounted lower			has been contacted and is a			
	then the smok	e detector but the			3 more pull stations outside	_		
	air flow was sti	rong and could			neighborhood offices identific			
	adversely affec	t the operation.			These will be before the exit			
	· ·	larm panel was			doors therefore will be acces			
	located in this				at all times. Work completio 8/15/2011 which will ensure			
		were provided by			alleged deficient practice do			
					not recur. <b>How the corrective</b>			
	the Facility Eng	jiileer.			action(s) will be monitored	to		
					ensure the deficient praction	:е		
	3.1-19(b)				will not recur, i.e., what qua	- 1		
					assurance program will be	put		
	2. Based on ol				into place: Environmental	_		
	interview, the f				Services will visually inspe the proper completion of the			
		manual fire alarm			required work. They will			
	boxes at the n	eighborhood			monitor proper operations	of		
	vestibule exits	and the nurses'			installed units randomly x (			
	stations were r	eadily accessible.			months. Findings will be			
	NFPA 72, The I	National Fire Alarm			reported to the Quality			
	Code, 2-8.2.1	states manual fire			Assurance Committee who			
	•	nall be distributed			determine the necessity for	·		
		protected area so			further audits.			
	1	tructed, readily						
	1 *	•						
		l located in the path						
	of exit from th	e area. This						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 03	(X3) DATE S COMPL		
1111212111	or conditions	155755	A. BUILDII B. WING	ING		07/27/2	
NAME OF I	DROLUDED OD CLUDDI IED			STREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		I .		DEGLEIN ROAD		
GOLDEN	I YEARS HOMESTE	EAD	F	FORT W	/AYNE, IN46815		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		1	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		EFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
		ce affects thirty	1				
	· -	undred residents.					
	Findings includ	e:					
	Based on obser	vations with the					
	Facility Enginee						
	I -	to 2:40 p.m., the					
		rm pull station at					
	Chestnut Place	e, Hickory Ridge and					
		y accessible in that					
	the pull station						
	l -	gnetically locked					
	I	would require the					
		b to access the pull					
	stations. Addit	ional manual fire					
	alarm pull stati	ons are located at					
		ation located near					
	each vestibule						
		ırses' station doors					
	will be locked.						
	acknowledged Engineer at the						
	observations.	time Of					
	2550174010113.						
	3.1-19(b)						
K0144 SS=C		spected weekly and ead for 30 minutes per nce with NFPA 99.					
	Based on obser		K014	44	This provider inspects their generator weekly and exerc		08/25/2011
	interview, the f	acility failed to			generator weekly and exerc	1303	

STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	03	COMPLETED
		155755	B. WIN			07/27/2011
		<u> </u>	D. (11)		DDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	OEGLEIN ROAD	
GOLDEN	YEARS HOMEST	EAD		1	VAYNE, IN46815	
(X4) ID		STATEMENT OF DEFICIENCIES	_	ID	,	(V5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	•	· · · · · · · · · · · · · · · · · · ·	+		it under load for 30 minutes	-
	ensure 1 of 1 e	- ·			month in accordance with	, , , , ,
	_	s equipped with a			NFPA 99.What corrective	
		l stop. LSC 7.9.2.3			action(s) will be accomplish	ned
	requires emerg	gency generators			for those residents found to	
	providing power	er to emergency			have been affected by the	
	lighting system	ns shall be installed,			deficient practice? No resid	ent
	tested and mai	ntained in			was affected by the alleged deficient practice. How will y	ou
	accordance wit	:h NFPA 110,			identify other residents have	l l
	Standard for Er	mergency and			the potential to be affected	-
	Standby Power	Systems. NFPA			the same deficient practice	and
	110, 1999 edit	•			what corrective action will	
		I installations shall			taken?No resident was affect	
	· ·	manual stop station			by the alleged deficient pract MacAllister Power Systems I	
		ar to a break-glass			been contacted to add a rem	II
		outside the room			emergency stop to a remote	
					outside the generator cabine	t.
	1	ime mover. NFPA			This work will be completed	
		or the Installation			8/15/2011. What measures v	VIII
		tionary Combustion			be put into place or what systemic changes you will	
	1 -	as Turbines, 1998			make to ensure that the	
	Edition, at 8–2	.2(c) requires			deficient practice does not	
	engines of 100	horsepower or			recur? MacAllister Power	
	more have pro	vision for shutting			Systems has been contacted	l l
	down the engi	ne at the engine and			add a remote emergency sto	p to
	from a remote	location. This			a remote area outside the generator cabinet. This work	c will
	deficient practi	ice could affect all			be completed on 8/15/2011.	· ····
	occupants.				Environmental Services will	
					visually inspect for proper	
	   Findings includ	łe·			completion of the required w	l l
	ags metac				This permanent repair will pr the alleged practice from	event
	Rased on obser	rvation with the			recurring. How the corrective	e
					action(s) will be monitored	l l
		er on 07/27/11			ensure the deficient practic	e
	_	of the facility from			will not recur, i.e., what qua	- I
	11:30 a.m. to a	2:35 p.m., the only			assurance program will be	put

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CC  A. BUILDING  B. WING	03	(X3) DATE SURV COMPLETED 07/27/2011	
	PROVIDER OR SUPPLIER		3136 G	ADDRESS, CITY, STATE, ZIP CODE OEGLEIN ROAD WAYNE, IN46815	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE CO.	(X5) MPLETION DATE
	manual stop fo generator was generator. The have a remote emergency gen an interview wi Engineer at 10:	r the emergency located on the e facility did not manual stop for the lerator. Based on th the Facility		into place: Environment Services will visually in for proper operations or generator during month inspections. Findings were reviewed by the Quality Assurance Committee we determine the necessity future inspections.	spect the ly vill be vho will	
			•			